Name_____ Age: _____ Height: _____ Weight: _____

Date of Onset _____ Referring Physician: _____ Next MD Appt: _____

Primary Care Physician: _____ When was your last visit? _____ Is an attorney involved? □ Yes □ No

Are you currently working? _____ What is/was your occupation? _____ Employer: _____

Was your injury work related? □ Yes □ No Date of Injury: ____/_____/_____

Was your injury the result of an automobile accident? □ Yes □ No Date of Accident: ____/_____/_____

Have you had any Diagnostic test for this condition? (i.e. Xray, MRI, etc.) If yes, please list type and date

_____ ___/___/_____ _____ ___/___/_____ _____ ___/___/_____

Please list any surgeries and any conditions for which you have been hospitalized, along with the dates

_____ ___/___/_____ _____ ___/___/_____ _____ ___/___/_____

In the past month, have you been feeling down, depressed, or hopeless? □ Yes □ No
In the past month, have you lost interest or had little pleasure in things? □ Yes □ No
How many alcoholic drinks do you have in a typical week? _____

Have you had a fall in the last year? □ Yes □ No How many falls? _____

If you have fallen the in the last year, did you sustain an injury? □ Yes □ No

Women: Are you currently pregnant or think you might be pregnant? □ Yes □ No

Please list any medication you are taking, along with the dosages and frequency

_____ ___mg ___/day _____ ___mg ___/day

_____ ___mg ___/day _____ ___mg ___/day

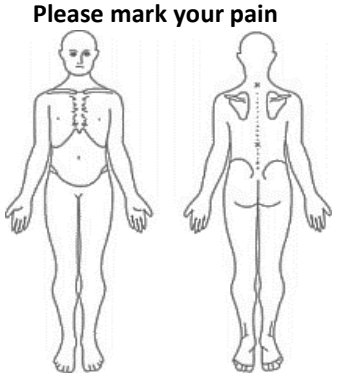
_____ ___mg ___/day _____ ___mg ___/day

Please rate your pain (circle current level)

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Please mark your pain



Have you ever been diagnosed with any of the following conditions?

□ Cancer
□ Headaches
□ Hepatitis
□ Depression
□ Anemia
□ Parkinson's
□ Diabetes
□ Osteoporosis
□ Anemia
□ Alzheimer's
□ Heart Problems
□ Pacemaker
□ Rheumatoid Arthritis
□ Sleeping Problems
□ Orthopedic Surgery
□ Seizures / Epilepsy
□ Stroke / TIA
□ High Blood Pressure
□ Weight / Energy Loss
□ Circulation Problems
□ Emphysema / Bronchitis
□ Chemical Dependency
□ Urinary Incontinence
□ Fecal Incontinence
□ Pregnancy
□ Tuberculosis
□ Multiple Sclerosis
□ Vision / Hearing Problems

Have you recently noted any of the following?

Weight Loss / Gain	□ Yes □ No
Nausea / Vomiting	□ Yes □ No
Dizziness / Lightheadedness	□ Yes □ No
Malaise	□ Yes □ No
Weakness	□ Yes □ No
Fever / Chills / Sweats	□ Yes □ No
Numbness / Tingling	□ Yes □ No
Night Pain	□ Yes □ No

What are your goals for Physical Therapy? _____

What aggravates your pain? _____

What makes your pain better? _____

I, hereby agree and give my consent to medical treatment in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize payment to Focus Physiotherapy, LLC regardless of participation in or out-of-network. Should I default on my financial responsibility and collection is necessary, I will be responsible for collection costs that are incurred.

Patient / Guardian Signature_____ Date: _____

Therapist Signature_____ Date:_____

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Privacy Policy

Focus Physiotherapy wants you to know how your Protected Health Information (**PHI**) will be used in our office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you online or at the front desk before signing this consent.

- The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff have been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physical therapist has the right to refuse to give care.

Is there anyone we are able to share your health information with regarding your care, your appointment times and dates, or your payments related to your care? ☐ YES ☐ NO

If yes, contact person(s) name _____

How did you hear about us? Please circle one.

1. Physician
2. Past Patient
3. Friend or Family Member
4. Co-worker
5. Work Related Injury
6. Internet, Website
7. School, Club, Sports Team
8. Other Advertising
9. Other _____

I, the undersigned, attest that I have read the above statements, understand them, and have had my questions answered.

_____ _____

Patient / Guardian Signature Date

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Appointment Policy

It is the policy to Focus Physiotherapy to schedule your appointments as the most convenient time slot, as to ease the difficulty to physical therapy appointments. If you are unable to attend one of your appointments, please provide us with a 24-hour notice. This will allow us to adjust our schedules to offer the best service to all patients.

Should you have to cancel an appointment, we will work with you in all possible ways to get that appointment rescheduled. It is best for your health and recovery to maintain the prescribed plan of care. It is our intent to provide the most appropriate care for your condition. If you do not call to cancel and fail to show for an appointment, we will call you that same day to reschedule that appointment.

If you are going to be late for an appointment, please call to let us know, so we can adjust our schedules as necessary. We will make all reasonable efforts to administer your full treatment, however time restraints may limit us from doing so.

If you miss 3 scheduled appointments, we will send a notice to your referring physician informing him / her that the plan of care has not been adhered to and that the therapist may choose to discharge your case. There are many life events which may impact your ability to attend therapy and will always work with you during such events to ensure your complete rehabilitation.

Informed Consent

I understand that as a patient of Focus Physiotherapy,

- I have the right to complete and current information concerning my diagnosis (to the degree known by Focus Physiotherapy), treatment, and any known prognosis. My therapist will communicate this information to me and ensure I understand it.
- I have the right to accept or refuse medical treatment to the extent allowed by law. I will be informed of the medical consequences should I refuse treatment. I understand that should I refuse medical treatment, Focus Physiotherapy has the right to terminate our relationship.
- I have the right to discuss and have all my questions answered regarding “Patient’s Rights”, which will be posted in a prominent area.

Automobile Accident

If your health problem is the result of an auto accident, you must provide us with your auto insurance information and your major medical insurance information. We will file your claims with your auto carrier if you have opened a personal car insurance medical pay claim, otherwise we will file your medical insurance. We do not file third-party payers. You do have the option to self-pay should you choose to not file your personal car insurance medical pay or medical insurance.

I, the undersigned, attest that the above policies have been explained to me and I have had all my questions answered.

_____ _____

Patient Signature Date